CHILD-TEEN HEALTH HISTORY

Name _____ Date of Birth _____

Preferred or Nickname _____ Social Security No. _____

Address _____ Home Phone _____

City _____ State _____ Zip Code _____

Whom may we thank for this referral? _____

How would you like your appointments confirmed? Phone Email Text (Circle One) Email Address:

PARENT/GUARDIAN INFORMATION

Person Responsible for this Account _____

Drivers License No _____ I will pay by: Cash ☐ Check ☐ Credit Card ☐

Father's name _____ Birth Date _____ Work Phone No _____

Father employed by _____ Dental Insurance _____ Cell Phone _____

Employers Address _____ SS#/Contract Number _____

Social Security No _____ Group No _____ Employee No _____

Mother's name _____ Birth Date _____ Work Phone No _____

Mother employed by _____ Dental Insurance _____ Cell Phone _____

Employers Address _____ SS#/Contract Number _____

Social Security No _____ Group No _____ Employee No _____

Now	Past	No		Now	Past	No		Now	Past	No	
			Heart Murmur				Excessive Bleeding				Physical/Mental Restrictions
			Mitral Valve Prolapse				Diabetes				Malignancies/Cancer
			Rheumatic Fever				Hypoglycemia				Radiation/Chemotherapy
			Hyperactivity				Thyroid Disorders				Anemia/Leukemia
			Heart Problems				Kidney Disorders				Seizures, Fainting Spells
			High Blood Pressure				Hepatitis				Mononucleosis
			Low Blood Pressure				Liver Problems				Tuberculosis (TB)
			Circulatory Problem				Glaucoma				Ulcer
			Stroke				Vision Problems				Measles/Mumps/C Pox
			Mastoid Problems				Hearing Loss				Exposure or tested for AIDS
			Allergy to Anesthetics				Nervous Problems				Cerebral Palsy
			Allergy to Med/Drugs				Psychiatric Care				Blood Transfusions
			Arthritis, Phys. Disab.				Frequent Headaches				Chronic Fatigue Syndrome
			Joint/Bone Replacements				Jaw/Facial Pain				Bladder Problems
			Asthma/Respiratory				Neck/Back Pain				Hospitalization
			Tobacco Use_____Yrs.				Chronic Sinus				Fainting

Does your child have Latex Allergies? Yes _____ No _____

Does your child need to be pre-medicated for their dental appointments? _____ Pharmacy _____

List Any Allergies: _____

Is your child developmentally disabled? _____ Please explain. _____

Is your child now taking any medication? _____ Please List _____

Name of family Doctor(s) _____

Other Pertinent Information _____

Current Dental Concerns _____

Signature of Parent or Guardian _____ **Date** _____

_____ Date _____ _____ Date _____ _____ Date _____ _____ Date _____